

Summerset Care Limited - Summerset Down The Lane

Current Status: 11 August 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Summerset Down the Lane is part of the Summerset group and opened in October 2013. The facility is certified to provide hospital (geriatric and medical) and rest home level care for up to 30 residents in the care centre and ten rest home residents in the serviced apartments. On the day of the audit there were nine hospital residents and 19 rest home residents in the care centre, and three rest home residents in serviced apartments. Summerset Down the Lane's village manager and nurse manager are well qualified for their roles. There are developed systems and policies that are in the process of being implemented to guide care for residents. A quality programme is being implemented. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

There are improvements required around meeting minutes, corrective action plan closure, incident reporting, activities, interventions, and medication management.

Audit Summary as at 11 August 2014

Standards have been assessed and summarised below:

Key

| Indicator | Description | Definition |
|-----------|---|---|
| | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
| | No short falls | Standards applicable to this service fully attained |
| | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
| | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |

| Indicator | Description | Definition |
|-----------|--|---|
| | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

Consumer Rights as at 11 August 2014

| | | |
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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Organisational Management as at 11 August 2014

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|---|--|---|
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
|---|--|---|

Continuum of Service Delivery as at 11 August 2014

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|--|--|--|
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Safe and Appropriate Environment as at 11 August 2014

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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Restraint Minimisation and Safe Practice as at 11 August 2014

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|---|--|--|
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
|---|--|--|

Infection Prevention and Control as at 11 August 2014

| | | |
|---|--|--|
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
|---|--|--|

Audit Results as at 11 August 2014

Consumer Rights

Summerset Down the Lane provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are in the process of being implemented to support residents' rights. A staff training programme is being implemented that supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

Organisational Management

Summerset Down the Lane is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are three improvements required around meeting minutes, corrective action plan closure and incident reporting.

Continuum of Service Delivery

The service has assessment processes and residents needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available and implemented. Service delivery plans are individualised. Short term care plans are in use for changes in health status. There are

improvements required around the documentation and implementation of interventions to reflect the resident's current needs. There is a diversional therapist employed to develop and implement a Monday to Friday programme. The programme activities are meaningful and reflect ordinary patterns of life. There are outings into the community, volunteer involvement and visiting entertainers. There is an improvement required around aligning the programme and the diversional therapist hours and days of work and reviewing the activity plan at the same time as the care plan. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There is an improvement required around medication fridge temperature monitoring and general practitioner (GP) signature for discontinued medications. Food services policies and procedures are appropriate to the service setting. The food service is contracted to Medirest. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were very complimentary of the food service provided and report that individual preferences are well catered. Additional snacks are available if the kitchen is closed.

Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. The service is currently operating under a code of compliance dated December 2013. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Visual inspection evidences compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals. Documented systems are in place for essential, emergency and security services. Staff interviews and review of files provides evidence of current training in relevant areas. Visual inspection evidences alternative energy and utility sources are maintained, an appropriate call bell system is available and security systems are in place. Bathrooms are large enough to cater for the needs of rest home and hospital level residents. Rooms are personalised.

Restraint Minimisation and Safe Practice

There are documented policies and procedures around restraint use and use of enablers. Currently there are no residents using restraint and one with an enabler.

Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.

The use of restraint and enablers is reported to the monthly quality meeting (meeting minutes sighted). There is a restraint co-ordinator and restraint approval group that meet three monthly.

Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for orientating new staff. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

| | |
|---|--|
| Legal entity name: | Summerset Care Limited |
| Certificate name: | Summerset Care Limited - Summerset Down the Lane |
| Designated Auditing Agency: | Health and Disability Auditing New Zealand Limited |
| Types of audit: | Certification Audit |
| Premises audited: | Summerset Down the Lane |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 11 August 2014 End date: 12 August 2014 |
| Proposed changes to current services (if any): | |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 31 |

Audit Team

| | | | | | |
|--------------------------|-------|----------------------------|-------|-----------------------------|---|
| Lead Auditor | XXXXX | Hours on site | 14.75 | Hours off site | 8 |
| Other Auditors | XXXXX | Total hours on site | 14.75 | Total hours off site | 8 |
| Technical Experts | | Total hours on site | | Total hours off site | |
| Consumer Auditors | | Total hours on site | | Total hours off site | |
| Peer Reviewer | XXXXX | | | Hours | 2 |

Sample Totals

| | | | | | |
|--|------|-----------------------------------|----|--------------------------------------|------|
| Total audit hours on site | 29.5 | Total audit hours off site | 18 | Total audit hours | 47.5 |
| Number of residents interviewed | 6 | Number of staff interviewed | 9 | Number of managers interviewed | 2 |
| Number of residents' records reviewed | 6 | Number of staff records reviewed | 9 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 35 | Number of relatives interviewed | 3 |
| Number of residents' records reviewed using tracer methodology | 2 | | | Number of GPs interviewed | 1 |

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

| | | |
|----|--|----------------|
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Not Applicable |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Thursday, 4 September 2014

Executive Summary of Audit

General Overview

Summerset Down the Lane is part of the Summerset group and opened in October 2013. The facility is certified to provide hospital (geriatric and medical) and rest home level care for up to 30 residents in the care centre and ten rest home residents in the serviced apartments. On the day of the audit there were nine hospital residents and 19 rest home residents in the care centre, and three rest home residents in serviced apartments. Summerset Down the Lane's village manager and nurse manager are well qualified for their roles. There are developed systems and policies that are in the process of being implemented to guide care for residents. A quality programme is being implemented. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

There are improvements required around meeting minutes, corrective action plan closure, incident reporting, activities, interventions, and medication management.

Outcome 1.1: Consumer Rights

Summerset Down the Lane provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are in the process of being implemented to support residents' rights. A staff training programme is being implemented that supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

Outcome 1.2: Organisational Management

Summerset Down the Lane is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are three improvements required around meeting minutes, corrective action plan closure and incident reporting.

Outcome 1.3: Continuum of Service Delivery

The service has assessment processes and residents needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available and implemented. Service delivery plans are individualised. Short term care plans are in use for changes in health status. There are improvements required around the documentation and implementation of interventions to reflect the resident's current needs. There is a diversional therapist employed to develop and implement a Monday to Friday programme. The programme activities are meaningful and reflect ordinary patterns of life. There are outings into the community, volunteer involvement and visiting entertainers. There is an improvement required around aligning the programme and the diversional therapist hours and days of work and reviewing the activity plan at the same time as the care plan. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There is an improvement required around medication fridge temperature monitoring and general practitioner (GP) signature for discontinued medications. Food services policies and procedures are appropriate to the service setting. The food service is contracted to Medirest. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were very complimentary of the food service provided and report that individual preferences are well catered. Additional snacks are available if the kitchen is closed.

Outcome 1.4: Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. The service is currently operating under a code of compliance dated December 2013. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Visual inspection evidences compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals. Documented systems are in place for essential, emergency and security services. Staff interviews and review of files provides evidence of current training in relevant areas. Visual inspection evidences alternative energy and utility sources are maintained, an appropriate call bell system is available and security systems are in place. Bathrooms are large enough to cater for the needs of rest home and hospital level residents. Rooms are personalised.

Outcome 2: Restraint Minimisation and Safe Practice

There are documented policies and procedures around restraint use and use of enablers. Currently there are no residents using restraint and one with an enabler. Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.

The use of restraint and enablers is reported to the monthly quality meeting (meeting minutes sighted). There is a restraint co-ordinator and restraint approval group that meet three monthly.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for orientating new staff. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

Summary of Attainment

| | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|------------------|----|----|---------------|--------|-------------|---------|-------------|
| Standards | 0 | 40 | 0 | 4 | 1 | 0 | 0 |
| Criteria | 0 | 87 | 0 | 5 | 1 | 0 | 0 |

| | UA Negligible | UA Low | UA Moderate | UA High | UA Critical | Not Applicable | Pending | Not Audited |
|------------------|---------------|--------|-------------|---------|-------------|----------------|---------|-------------|
| Standards | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| Criteria | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|------------|---|--|------------------|
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results | PA Low | Meeting minutes do not always record follow up as prescribed, eg; | a) Meeting minutes record matters arising and progress towards same, b) Where an | 180 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|------------|--|--|------------------|
| | | communicated to service providers and, where appropriate, consumers. | | <p>a) Quality Initiative Register reports the introduction of a 'Swapped Staff Form' and records follow-up to be taken to the clinical update meeting 31 July 2014. Clinical update meeting minutes of 17 July 2014 and 25 July 2014 do not mention the form (there were no meeting minutes for the 31 July 2014 available).</p> <p>b) Clinical update/care staff meeting against 'resident file audit' states the due date for completed actions (as a result of internal audit) as 25 June 2014. There is no record in the meeting minutes 19 June 2014 of progress against this action, and while the item was reported in the minutes 04 July 2014, the due date for completion remains at 25 June 2014.</p> | action is recorded (eg. from the quality initiative register and/or as part of a corrective action) evidence of discussion/follow up is minuted at the prescribed meeting. | |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | There are a number of instances where the section 'issues have now been resolved' has not been completed on corrective action plans including: the code of rights audit (February), file review and medication review (June) – valuables form, MDT review – family to sign changes, consent form completion, keyworker documentation. The corrective action plan has been signed as closed. | Complete the corrective action plan form as prescribed. | 180 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected | PA Low | | | |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--|---|-------------|---|---|------------------|
| | | consumers and where appropriate their family/whānau of choice in an open manner. | | | | |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Two (of four) resident files traced reported: a) '....acquired a skin tear....' and b) '...bottom very red and raw....' There was no associated incident forms. | Changes in resident health status are reported through the incident reporting process. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | (i) The care plan does not reflect current needs for one rest home resident with continence problems. 2) There is no short term care plan in place for one rest home resident with a fall with injury. There is no documented evidence of GP notification. 3) There is no further documented intervention for one rest home resident with continuing weight loss. 4) There are no documented risks associated with the use of an enabler. | (i) Ensure that interventions are documented to reflect current needs for residents with continence problems (link 1.3.3). 2) Ensure short term care plans are in place for falls with injury and GPs are notified. 3) Ensure continuing weight loss is monitoring and interventions implemented. 4) Ensure risks associated with enabler use is included in the assessment and care plan (link 1.3.3). | 60 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | | | |

| | | | | | | |
|--------------|--------------------------------------|---|--------|--|--|----|
| HDS(C)S.2008 | Criterion 1.3.7.1 | Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The DT works a four days on and four days off roster (five hours a day). Advised the caregivers implement the activity programme on the DT four days. There is no documented evidence to support the activity plan is being implemented as per the programme over the four day period the DT is not on-site. | Ensure the planned activity programme is implemented. | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | 1) Fridge temperature recordings have been consistently below the acceptable temperature range over the last two months. There is no evidence of corrective actions 2) Five out of 12 medication charts did not evidence a GP signature for discontinued medications. | 1) Ensure medication fridge temperatures are maintained between 2-8 degrees Celsius. 2) Ensure the GP signs for discontinued medications. | 30 |

Continuous Improvement (CI) Report

| Code | Name | Description | Attainment | Finding |
|------|------|-------------|------------|---------|
| | | | | |

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Attainment and Risk: FA

Evidence:

Summerset has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the in-service programme. Interview with three caregivers (who work across care centre and serviced apartments) demonstrate an understanding of the Code. Elder abuse training is scheduled to be provided in August 2014. Residents interviewed (four rest home and two hospital) and relatives (one rest home and two hospital) confirm staff respect privacy, and support residents in making choice where able.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed through the facility. The resident and family meetings (first meeting held June 2014) also provide the opportunity for residents to raise issues (minutes sighted). Residents interviewed (four rest home and two hospital) and relatives (one rest home and two hospital) inform information has been provided around the Code. The village manager and nurse manager inform an open door policy for concerns or complaints. D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, CoR pamphlet, advocacy and Health & Disability Commission. The nurse manager and registered nurses describe discussing the information pack with residents/relatives on admission. D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Attainment and Risk: FA

Evidence:

There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files are stored out of sight. Staff could describe aspects of abuse and neglect with training scheduled for August (2014). Three relatives interviewed stated that the care provided is very good and staff are respectful. A resident satisfaction survey is completed annually and at the time of audit the results were being aggregated.

Refer evidence in 1.2.3 re a recent quality initiative promoting resident dignity.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with three caregivers (who work across care centre and serviced apartments) describe how choice is incorporated into resident cares. Residents interviewed (four rest home and two hospital) and relatives (one rest home and two hospital) inform staff are respectful. There is an abuse and neglect policy being implemented. Interviews with residents and family members were positive about the care provided.

D4.1a Six resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with residents confirm their values and beliefs were considered.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA

Evidence:

A3.2 Summerset has a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. One Maori resident interviewed informed staff are respectful of cultural values and beliefs.

D20.1i There are policies being implemented that guide staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with three relatives inform values and beliefs are considered. Residents interviewed (four rest home and two hospital) confirm that staff take into account their culture and values.

D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.

D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Staff receive training on professional boundaries (February 2014) and meetings include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the nurse manager confirms an awareness of professional boundaries. Interview with three caregivers (who work across care centre and serviced apartments) could discuss professional boundaries in respect of gifts.

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

Summerset has a suite of appropriate policies and procedures that are updated as necessary. There is an established quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group is undertaken. There is an active culture of on-going staff development with the Careerforce programme and an in-service schedule that is being implemented – participation in Careerforce is compulsory for care staff. There is evidence of education being supported outside of the training plan.

ARC A2.2 Services are provided at Summerset that adhere to the health & disability services standards.

ARC D1.3 all approved service standards are adhered to.

ARC D17.7c There are implemented competencies for caregivers and registered nurses including but not limited to: insulin administration, medication, wound care and manual handling. RNs have access to external training.

Residents interviewed (four rest home and two hospital) and relatives (one rest home and two hospital) were positive about the care they receive. Interview three caregivers (who work across care centre and serviced apartments) inform they are well supported by the registered nurses (RN)'s and management team.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten of ten incident forms reviewed across June and July identify family were notified following a resident incident. Interview with three caregivers (who work across care centre and serviced apartments), the nurse manager and one RN inform family are kept informed.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b relatives (one rest home and two hospital) stated that they are informed when their family members health status changes.

D11.3 The information pack is available in large print and this can be read to residents.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA

Evidence:

The informed consent form includes medical, manual handling (no lifting), transport, purchases and charges. Informed consent information is included in the information pack for new residents. The consent policy includes clear instructions for providing information to residents during the admission process. The nurse manager discusses informed consent processes with residents and their families during the admission process. Six of six residents (four rest home and two hospital) and relatives (one rest home, two hospital) interviewed confirmed that informed consent has been discussed with them. Consent is gained for procedures outside of normal care. Examples sighted in resident files include consent to have a catheter changed (one file) and consent for wounds to be photographed (two files). There is an advanced directive policy, a not for resuscitation policy and a not for resuscitation authorisation by competent resident form, a not for resuscitation authorisation for incompetent resident form and a resuscitation authorisation form. Completed resuscitation treatment plans and resuscitation advance directive forms were completed on six of six files (four rest home including one from a serviced apartment and two hospital) and they are all signed appropriately. The nurse manager and RNs are responsible for ensuring general consent is gained on admission.

Discussions with three caregivers confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions

with two registered nurse identified that they are familiar with advanced directives and the fact that only the resident (deemed competent) can sign the advance directive.
D13.1 Six admission agreements sighted had been signed on the day of admission
D3.1.d Discussion with three relatives identified that the service actively involves them in decisions that affect their relative's lives.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

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| Attainment and Risk: FA |
| Evidence: Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the village manager and nurse manager confirm practice. Interviews with residents (four rest home and two hospital) confirm that they are aware of their right to access advocacy. D4.1d; Discussions with three family members confirm that the service provides opportunities for the family/EPOA to be involved in decisions ARC D4.1e. The resident files include information on residents' family/whanau and chosen social networks. |

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: FA

Evidence:

D3.1h: Interview with six residents and three relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Interviews with six residents confirm the activity staff help them access the community such as going shopping, going on sightseeing tours, and going to church.

D3.1.e Discussion with three caregivers, the diversional therapist, three relatives and six residents confirm residents are supported and encouraged to remain involved in the community and external groups.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA

Evidence:

There is a complaints policy to guide practice. The village manager leads the investigation and management of complaints (verbal and written). All complaints are entered into 'sway' (Summerset way), the electronic database, where action taken and close out date is recorded. Complaints are discussed at the monthly quality meeting. Complaints forms are visible around the facility. Interview with the village manager and review of the electronic process indicates a total of 17 complaints from care centre residents (including the rest home residents in the serviced apartments) have been received across the 2014 year. There is evidence of action taken.

There are a number of templates in the 'sway' system that can be used to manage complaints, such as an acknowledgement letter. Electronic notification is sent to the village manager if prescribed timelines are not being met. At the time of audit there is one complaint open, a meeting is scheduled to progress the day following the audit. Residents interviewed (four rest home and two hospital) and relatives (one rest home and two hospital) confirm they are aware of how to make a complaint. There have been a number of compliments that have been received across the 2014 period.

D13.3h. a complaints procedure is provided to residents within the information pack at entry.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p> |
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Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p> |
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Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA

Evidence:

Summerset provides care for up to 30 residents in the care centre across two service levels (rest home and hospital). On the day of audit there were 19 rest home residents and nine hospital residents. The care centre rooms have previously been assessed as dual purpose. The serviced apartments have also been assessed as suitable for rest home level care (up to ten rest home residents) and at the time of audit there were three rest home residents in the apartments. This makes a total of 31 rest home/hospital residents at the time of audit.

The service inform there are plans to build an additional 20 rest home/hospital beds and ten apartments, target for completion is March 2015.

There is a 2010-2015 risk management plan, a pandemic health plan and a 2014-2015 business plan. The business plan outlines organisational goals such as the provision of high quality nursing care and minimising clinical risk. One of the clinical targets linked to this goal is to reduce falls and skin tears by 20%. Each village then develops plan/s to achieve targets including date/s.

Summerset has a 'clinical audit, training and compliance' calendar that is being implemented at Summerset Down the Lane. The calendar schedules the training and audit (etal) requirements for the month and the village manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet includes reporting including (but not limited to): meetings held, induction/orientation, audits, Careerforce, competencies, projects. This reporting format has been in place for approximately four months and is sent to head office as part of the on-going monitoring programme. There is a monthly quality meeting at Summerset Down the Lane that includes discussion about clinical indicators (eg. incident trends, infection rates).

The service is managed by a non-clinical village manager who has been in post since February (2014). She has an estimated 30 years' experience in aged residential settings. She is supported by a nurse manger (registered nurse) who has been in post for seven months. The nurse manager has had approximately ten years' experience in similar roles within aged residential settings. There is a team of registered nurses and care staff.

ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA

Evidence:

The village manager and nurse manager are both on call 24/7 and neither are on leave at the same time. If the nurse manager is on leave, a senior registered nurse is nominated to provide senior [clinical] cover.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: PA Low

Evidence:

Summerset Down the Lane is implementing the organisation's quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.

The Summerset group has a 'clinical audit, training and compliance' calendar that is being implemented at Summerset Down the Lane. The calendar schedules the training and audit (etal) requirements for the month and the village manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet includes reporting including (but not limited to): meetings held, induction/orientation, audits, Careerforce, competencies, projects. This reporting format has been in place for approximately four months and is sent to head office as part of the on-going monitoring programme.

There is a monthly quality meeting that includes discussion about clinical indicators (eg. incident trends, infection rates). Summerset Down the Lane infection control and health & safety committees both meet three monthly, noting the infection control committee meetings commenced May 2014. A report is provided to the quality meeting from these committee meetings. Information is then discussed at the weekly care staff/clinical update meetings and the monthly registered nurse meetings. There is a quality initiative register that records the projects being undertaken by the facility. There are instances where information is not consistently recorded/followed through month to month and this is an area for improvement.

Resident/family meetings have recently been established and an annual survey has been completed with the results being aggregated at the time of audit. A meal satisfaction survey has been undertaken and a corrective action plan has been put in place as a result of feedback received.

Summerset Down the Lane is implementing an internal audit programme that includes aspects of clinical care – such as monthly file review. Issues arising from internal audits are developed into a corrective action plan. The prescribed form includes an entry ‘the issues have now been resolved’, and there are instances where this has not been signed out and this is an area for improvement.

The facility has reported a number of quality initiatives across recent months, and spoke in particular of the project around clothing protectors. This initiative came about following a relative who expressed unease with the use of ‘bibs’ in the dining room. As a result village residents were involved in personalising the current clothing protectors to individual residents. This has taken steps to remove the institutional nature of the ‘bibs’ and supported resident dignity.

D19.3: There is a comprehensive H&S and risk management programme in place including policies to guide practice. The property manager is the health and safety coordinator for the facility who, with the committee monitors staff accidents and incidents as part of the three monthly meeting.

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. There is an organisational goal to reduce falls by 20% for the year.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: PA Low

Evidence:

There are a range of meetings held to collect report and analyse quality data including a monthly quality meeting, three monthly health & safety, infection control and restraint meetings. Staff are informed of quality activities at the weekly care staff/clinical update meeting and/or the monthly registered nurse meeting. There is a quality initiative register that records quality projects that are in place, this register also notes where follow up at one or other of the meetings is to take place.

Finding:

Meeting minutes do not always record follow up as prescribed, eg;

a) Quality Initiative Register reports the introduction of a 'Swapped Staff Form' and records follow-up to be taken to the clinical update meeting 31 July 2014. Clinical update meeting minutes of 17 July 2014 and 25 July 2014 do not mention the form (there were no meeting minutes for the 31 July 2014 available).

b) Clinical update/care staff meeting against 'resident file audit' states the due date for completed actions (as a result of internal audit) as 25 June 2014. There is no record in the meeting minutes 19 June 2014 of progress against this action, and while the item was reported in the minutes 04 July 2014, the due date for completion remains at 25 June 2014.

Corrective Action:

a) Meeting minutes record matters arising and progress towards same, b) Where an action is recorded (eg. from the quality initiative register and/or as part of a corrective action) evidence of discussion/follow up is minuted at the prescribed meeting.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: PA Low

Evidence:

An internal audit programme is being implemented that includes aspects of clinical care – such as monthly file review. Issues arising from internal audits are developed into a corrective action plan. The prescribed form includes entries to record: ‘timeframe for resolution’ and ‘the issues have now been resolved’. There is an area for sign out. Interview with the clinical and quality manager informs completion of the form is Summerset practice.

Finding:

There are a number of instances where the section ‘issues have now been resolved’ has not been completed on corrective action plans including: the code of rights audit (February), file review and medication review (June) – valuables form, MDT review – family to sign changes, consent form completion, keyworker documentation. The corrective action plan has been signed as closed.

Corrective Action:

Complete the corrective action plan form as prescribed.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: PA Low

Evidence:

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the integrated meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the nurse manager for review and final sign off. Family are notified. Ten incident forms were reviewed and all had been completed appropriately and signed off. Four files were traced and there were two instances of broken skin reported in progress notes that did not have an associated incident form and this is an area of improvement.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: PA Low

Evidence:

Incident forms are completed by staff following an event. The resident is reviewed by the registered nurse at the time of event and the relevant section of the form completed. The form is forwarded to the nurse manager for final sign off, following which the form is filed into the resident record and scanned and reported through the 'sway' system. Family are seen to have been notified. Interview with the nurse manager confirmed an awareness of resident incidents and resulting outcomes.

Finding:

Two (of four) resident files traced reported: a) '...acquired a skin tear....' and b) '...bottom very red and raw....' There was no associated incident forms.

Corrective Action:

Changes in resident health status are reported through the incident reporting process.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA

Evidence:

There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Eight staff files were reviewed (nurse manager, one registered nurse who is the infection control coordinator, five caregivers one is a member of the health & safety committee, diversional therapist and property manager) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed (three caregivers, one registered nurse) were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. This includes all required education as part of these standards. The plan is being implemented. There is also an expectation care staff engage in the Careerforce programme – verified by three caregivers (who work across care centre and serviced apartments). A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, and kitchen). Core competencies are completed and a record of completion is maintained on staff files and well as being scanned into 'sway'. Staff interviewed are aware of the requirement to complete competency training. Summerset employs a clinical education manager who is a registered nurse with a current practising certificate. She facilitates the orientation programme for new staff and support the on-going education programme. There is a staff member with a current first aid certificate on every shift.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p> |
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Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p> |
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Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> |
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Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: village manager and nurse manager – both full-time Monday to Friday.

AM: 1x registered nurse, 2 care givers 0700-1500, 1 caregiver 0700-12midday, 1 caregiver 0800-1300, 1 caregiver serviced apartments

PM: 1x registered nurse, 2 caregivers 1500-2300, 1 caregiver 1600-2100, and 1 caregiver serviced apartments

ND: 1x registered nurse, 1 caregiver 2300-0700, and 1 caregiver serviced apartments.

There is at least one registered nurse and one first aid qualified person on each shift. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. An initial care plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident.

D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: FA

Evidence:

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| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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| Attainment and Risk: FA |
| Evidence: |
| On admission to services there is a needs assessment completed of residents and this is evident in six of six files reviewed (four rest home including one in a serviced apartment and two hospital). The nurse manager (NM) screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the |

resident. There is currently a waiting list for hospital level care. All enquiries are followed up with regular liaison with the family/social worker regarding pending admissions. Six residents (four rest home and two hospital) and three relatives (one rest home and two hospital) all stated that they received sufficient information on admission and discussion was held regarding the admission agreement. There is a well-developed information pack, which included advocacy, health and disability information, fees - where applicable, recreation services, menus and services available. There is a care facility - resident admission and orientation policy and procedure, the service has a comprehensive admission policy including that information gathered at admission is retained in resident's records.

D13.3 the admission agreement reviewed aligns with a) -k) of the ARC contract. Six signed admission agreements are sighted.

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The reason for declining service entry to residents is recorded and advised should this occur it is communicated to the resident or family/ whanau and they are referred to the original referral agent for further information.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3i; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

The service provides rest home and hospital level of care for up to 30 residents within the care centre and up to 10 rest home residents in the care apartments.

D.16.2, 3, and 4: The six resident files sampled (four rest home, two hospital) identifies the nurse manager or registered nurse (RN) completes an initial support plan within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and support plan. Six resident files sampled identified that the long-term care plan is developed within three weeks. There is documented evidence of multidisciplinary team reviews (MDT) held six monthly. The RN amends the long term care plan to reflect on-going changes as part of the review process. Allied health professionals involved in the residents care are linked to the long term care plan review as relevant. All six resident files sampled included evidence of resident/relative input into the initial assessment, care plan and reviews.

D16.5e: All six resident files reviewed identified that the general practitioner had seen the resident within two working days. It was noted in the six resident files reviewed that the general practitioner has assessed the resident as stable. There is a three month review stamp used that confirms the GP has sighted the residents observations, reviewed medications and states if the resident is stable and review frequency. There is evidence of the GP being involved in the three month MTD meetings with families. Currently there is a locum GP (interviewed) providing medical care in the absence of the regular GP. He is available to attend residents of concern and states call have been appropriate.

Three caregivers (who work across care centre and serviced apartments) and the nurse manager describe a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed. Progress notes are maintained on every shift by caregivers or more often if there are any changes. RNs write in the

medical continuation notes at least weekly and with significant events, GP visits, infections, falls etc. A progress review stamp is used in the car assistants notes to identify the RN has read their notes. All six resident files identify integration of allied health personnel and a team approach is evident. Activity assessments are completed by families where possible and activities plans are developed by the diversional therapist and reviewed six monthly.

Four rest home files were sampled. Two hospital files were sampled

Tracer Methodology rest home:

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer methodology hospital:

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: FA

Evidence:

The initial support plan is developed with information from the initial assessment. Clinical risk assessments including continence, safe handling, falls risk, pressure area risk, mini nutritional assessment, culture assessment, pain assessment, challenging behaviour and wound assessments are completed as applicable following admission and reviewed at least six monthly in all six resident files sampled.

Risk assessment tools are used to effectively assess level of risk and required support for residents. Continuing needs/risk assessments are carried out by registered nurses. Needs outcomes and goals of consumers are identified and these link to care plans including falls assessments, continence care and diet (link 1.3.6.1).

Six of six files sampled (four rest home and two hospital) contain all relevant assessments and these are current. Residents and relatives interviewed report having been involved in the assessment process.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Attainment and Risk: FA

Evidence:

Six care plans were reviewed for this audit, four rest home and two hospital. Assessment tools relevant to a specific area of the support plan are completed.

Residents' files include; daily progress notes, recordings - bowel and fluid charts, relative contact, care planning consultation record, long term care plan, risk assessment tools, short term care plans/wounds, enabler documentation, care plan evaluations (MDT review), GP initial assessment and visits, lab results, allied health reports/progress notes, activities, consents and advance directives, letters, referrals and archived notes.

Care plans demonstrate service integration and demonstrate input from allied health including physiotherapist, GPs, community nurse and podiatrist in files sampled. Notes are maintained by the general practitioner and allied health professionals and significant events, communication with families and notes (as required) are maintained by registered nurses.

D16.3k: Short term care plans are in use for changes in health status. Examples sighted (active and resolved) include; weight loss, pain, memory loss and skin tear (link 1.3.6.1).

D16.3f Six of six files sampled (four rest home and two hospital) reviewed identified that family were involved.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: PA Moderate

Evidence:

Summerset Down the Lane provides services for residents requiring rest home and hospital level of care. Overall, the care plans are completed comprehensively. Residents interviewed (four rest home and two hospital) state their needs are being met. Relatives interviewed (one rest home and two hospital) state their relatives receive care within a timely manner and they are kept informed of any health changes, GP visits and care plan reviews. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. There is an improvement required around the update of the care plan to reflect changes in the resident's continence status.

There is a wound assessment and on-going assessment and treatment plans in place for four wounds and four skin tears. There are photos and mapping grids where applicable. There is evidence of wound nurse practitioner and community nurse involvement where required for more complex wounds. Short term care plans are in place. Chronic wounds are linked to the long term care plan. Pressure area risk assessments are reviewed and interventions identified, documented and implemented for residents with pressure areas such as air alternating, mattresses, pressure area cushions and two hourly position changes. The nurse manager interviewed described the referral process should they require assistance from a wound specialist.

A resident's mood or behaviour is identified under emotional safety in the long term care plan. A behaviour assessment is completed on admission if applicable and for any new or altered behaviours. A behaviour management plan identifies triggers for behaviour and describes individual interventions including alternative strategies and activities. Behaviour is monitored and referrals to the geriatrician or mental health services are made through the GP as required.

Pain assessments are completed on admission for all residents with identified and on regular or prn pain relief. Pain assessments include non pharmaceutical strategies. Pain assessments are reviewed every six months and initiated for new or exacerbation of chronic pain. The effectiveness of pain relief is documented in the progress notes.

Falls risk assessments are completed for residents on admission and reviewed six monthly or earlier for resident falls. A post falls nursing assessment is carried out after each fall. Falls prevention strategies are identified, documented and implemented. For residents who falls frequently a repetitive falls screening tool is completed. A referral is made to the DHB physiotherapist and if more urgent to the contracted physiotherapist. There is no short term care plan in place for one rest home resident with a fall injury or documented evidence of GP notification and this is a required improvement.

Resident's weights are recorded on admission and monthly thereafter on the monthly weight chart. Interventions for weight loss as evidenced in the resident file of one rest home resident includes weekly weights, Mini Nutritional Assessments (MNA), high calorie diets, dietary supplements and GP notification however there is an improvement required around the monitoring and interventions for continuing weight loss. The dietitian can be accessed through the Medirest service.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: PA Moderate

Evidence:

Residents interviewed (four rest home and two hospital) state their needs are being met. Relatives interviewed (one rest home and two hospital) state their relatives receive care within a timely manner and they are kept informed of any health changes, GP visits and care plan reviews. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. Falls risk assessments are completed for residents on admission and reviewed six monthly or earlier for resident falls. A post falls nursing assessment is carried out after each fall. Falls prevention strategies are identified, documented and implemented. For residents who falls frequently a repetitive falls screening tool is completed. A referral is made to the DHB physiotherapist and if more urgent to the contracted physiotherapist. Residents weights are recorded on admission and recorded monthly thereafter on the monthly weight chart. Interventions for weight loss as evidenced in the resident file of one rest home resident includes weekly weights, **MNA assessments**, high calorie diets, dietary supplements.

Finding:

(i) The care plan does not reflect current needs for one rest home resident with continence problems. 2) There is no short term care plan in place for one rest home resident with a fall with injury. There is no documented evidence of GP notification. 3) There is no further documented intervention for one rest home resident with continuing weight loss. 4) There are no documented risks associated with the use of an enabler.

Corrective Action:

(i) Ensure that interventions are documented to reflect current needs for residents with continence problems. 2) Ensure short term care plans are in place for falls with injury and GPs are notified. 3) Ensure continuing weight loss is monitoring and interventions implemented. 4) Ensure risks associated with enabler use is included in the assessment and care plan.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: PA Low

Evidence:

The qualified diversional therapist (DT) has been with the service since June 2014 and has had seven years previous DT work experience. She works a four days on and four days off roster (five hours a day) that includes some weekend work. Advised the caregivers implement the activity programme on the DT four days off. There is no documented evidence to support the activity plan is being implemented as per the programme over the four day period the DT is not on-site. This is an area requiring improvement. The DT attends monthly DT committee meetings, on-site education and holds a current first aid certificate. The Monday to Friday combined (rest home and hospital) activities programme is planned a month in advance and includes (but not limited to); newspaper reading exercises, walks, ball games, board games, bowls,

pampering sessions, happy hour, knitting group, quilts, movies, cooking sessions and golf. Activities are planned that are appropriate to the functional capabilities of residents taking into consideration physical and cognitive abilities and sensory impairment. One on one time is spent with hospital level residents or those who choose not to participate in the groups and includes nail care, foot spas, massage and pamper sessions. Volunteers provide music and piano entertainment. Residents go out to community events such as concerts. Community visitors come into the home for chats and discussions with residents and there are visiting pets and family bingo sessions. Special events, festive occasions and birthdays are celebrated. There are monthly church services on a rotation basis for the churches. There are weekly van outings and resident provide feedback and suggestions for the outings. There is a planned trip to Mystery Creek in September.

D16.5d The activity assessment is completed in consultation with the family on admission. The activity care plan is developed within three weeks of admission and reviewed at the same time as the care plan.

Monthly progress notes are written. Six of six files sampled (four rest home and two hospital) have a documented activities plan.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: PA Low

Evidence:

The qualified diversional therapist (DT) has been with the service since June 2014 and has had seven years previous DT work experience. The Monday to Friday programme is planned a month in advance.

Finding:

The DT works a four days on and four days off roster (five hours a day). Advised the caregivers implement the activity programme on the DT four days. There is no documented evidence to support the activity plan is being implemented as per the programme over the four day period the DT is not on-site.

Corrective Action:

Ensure the planned activity programme is implemented.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

There is evidence of resident and family (where appropriate) involvement in the review of support plans.

D16.4a Six of six care plans sampled have a documented six monthly multidisciplinary care plan evaluation or earlier if there are changes to health status. There are short

term care plans to focus on acute and short-term issues. These are reviewed daily by a registered nurse until the issue is resolved or transferred to the long term care plan.
ARC D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA

Evidence:

D16.4c; The service provided examples of where a residents condition had changed and the resident was reassessed for a higher level of care.
D 20.1 Discussions with the nurse manager identified that the service has access to (but not limited to); speech language therapist, community physiotherapist, diabetic nurse, wound care nurse, needs assessment, social worker, geriatrician, age concern, dietitian and this was evidenced in seven files reviewed.
Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services.
Referral documentation is maintained on resident files.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. The files of one rest home residents who had recently been transferred to hospital is sampled. The nurse manager reports a transfer checklist and emergency care referral form is completed and sent with the resident. The file clearly documents in the progress notes the time the resident was admitted to hospital and the reason why, and that family were informed. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i.i.2; D18.2; D19.2d

Attainment and Risk: PA Low

Evidence:

The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. There is one locked medication room. The facility uses two weekly supplied robotic sachets for regular and prn medication delivered by the supplying pharmacy. Medications are checked against the signing sheets on arrival at the facility. Any discrepancies are fed back to the pharmacy. Returns are kept in locked case until collected by the pharmacy. There are records kept of medications received and returned. Expiry dates for prn medications are checked two weekly. All medications are kept in a locked trolley in the treatment room. All eye drops in use (sighted) are dated on opening. The medication fridge temperature is recorded daily however there is an improvement required around temperature monitoring. A stock of hospital medications is kept in the medication room. Standing orders are current, there is one resident self-medicating who has been assessed and is monitored daily for compliance. Advised by the company Quality manager the self-medication form is being reviewed to ensure a more comprehensive assessment is completed. All RNs and senior caregivers that administer medication are competent and have received medication management training. The RNs have completed syringe driver training. Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people and weekly stocktakes occur. The controlled drug administration sheet is signed by two medicine competent persons.

Twelve resident medication charts sampled are identified with photographs and allergy status. The prescribing of regular and prn medications meets legislative requirements. There is an improvement required around the discontinuation of medications.

D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: PA Low

Evidence:

All medications are kept in a locked trolley in the treatment room. All eye drops in use (sighted) are dated on opening. The medication fridge temperature is recorded daily. Twelve resident medication charts sampled are identified with photographs and allergy status. The prescribing of regular and prn medications meets legislative requirements

Finding:

1) Fridge temperature recordings have been consistently below the acceptable temperature range over the last two months. There is no evidence of corrective actions 2) Five out of 12 medication charts did not evidence a GP signature for discontinued medications.

Corrective Action:

1) Ensure medication fridge temperatures are maintained between 2-8 degrees Celsius. 2) Ensure the GP signs for discontinued medications.

Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA

Evidence:

There is a large kitchen and all food is cooked on site by external contractors. There is a comprehensive kitchen manual in place. The chef (interviewed) reports to the area manager for the Compass Group (interviewed). There is a qualified chef on duty Monday to Friday and a weekend cook. They are supported by a morning and afternoon catering assistant. The kitchen supplies food for the newly opened café on site. There is an eight week menu seasonal menu is in place. The company dietitian sends out the menu when due for review for site input into the menu plan. The chef receives a dietary profile for each resident with dietary requirements, special diets, food allergies, likes and dislikes. Alternatives are offered. The chef is notified of any dietary changes for the residents. Food is transported in hotboxes to the dining room where it is served from a bain marie. Special diets are plated and labelled. There are specialised cups, plates and utensils to promote resident independence at meal times. End cooked food temperatures and serving temperatures are recorded on each meal. The kitchen is well equipped with combi oven, gas hobs and oven and have not been in use a full year. The fridge and freezer have visual temperatures which are recorded daily. The facility fridges temperatures are monitored (records sighted). The pantry is well stocked and holds enough food for five days. All dry goods are sealed and dated. All perishable goods in the fridges are date labelled. Daily, weekly and monthly cleaning schedules are maintained. Chemicals are stored safely within the service. The chemical provider completes monthly service checks on the dishwasher and chemical use.

Feedback on the service and meals is by direct verbal feedback, residents comment book in the dining room (checked daily) and customer services.

D19.2: Staff working in the kitchen have food handling certificates and receive on-going training.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facilities and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances (November 2013). Designated cleaners cupboards are locked. Chemicals are stored safely throughout the facility. A visual inspection of the facility evidences the provision of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. These products were seen in sluice rooms and the laundry, gloves are in every ensuite and there are plentiful supplies of aprons. The service now has a standing order for personal protective equipment (PPE) to ensure it never runs out. Clothing is provided and used by staff. Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA

Evidence:

The Sway electronic database provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and maintenance requests are generated through the on-line system using the Sway programme. The facility opened in October 2013 and is currently operating under a Code of Compliance dated December 2013. There is a lift between the ground floor (care apartments) and the first floor (care centre). All medical equipment is under one year and still under warranty. Facility equipment is also under one year old and electrical testing and tagging is scheduled for November. The maintenance person for Summerset Down the Lane care centre and village is employed full-time and is available on call. A monthly maintenance schedule is generated on-line from head office and the maintenance person provides a monthly report. Hot water temperatures are recorded monthly and are consistently reading 42-45 degrees Celsius. Preferred contractors are available 24/7. A visual Inspection of the facility provides evidence of safe storage of medical equipment. Corridors are wide enough in all areas to allow residents to pass each other safely with safe access to communal areas and outdoor areas. There is outdoor seating and shade. There is no designated smoking area as there are no smoking residents.

ARC D15.3: The three caregivers, nurse manager and registered nurse (interviewed) state they have all the equipment required to provide the care documented in the care plans. The following equipment is available: electric beds, ultra low beds, sensor mats, shower chairs, hoists, mobility aids and wheel-on weigh scales.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

Visual inspection evidences toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All bedrooms have their own ensuite. There is a communal toilet located near the lounge/dining room. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately, secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

All bedrooms are spacious with ensuites. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists. The doors are wide enough for ambulance access and the lift is large enough for ambulance trolleys. Residents and families are encouraged to personalize their rooms as viewed. Six residents (four rest home and two hospital) confirmed they are happy with their bedrooms and have been able to personalise their personal space. .

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Communal areas within the facility include open plan lounge and dining area for the rest home and hospital residents, library and internet area and activity lounge. There is a family room available for visitors and one on one private discussions. There are several seating alcoves including a conservatory that looks out over the gardens. There is a gym in the care apartments that is open to residents and a village café that promotes community interaction.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA

Evidence:

There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry is well managed and dirty to clean flow is evident. All laundry is completed onsite by caregivers allocated to the care apartments. There are covered linen trolleys used by the caregivers. Laundry and cleaning are a seven day service. There are dedicated cleaners who work a four day on, four day off roster. Staff are observed wearing protective clothing while carrying out their duties. Cleaning trolleys are kept in designated locked cupboards. Residents and family interviewed report satisfaction with the cleaning and laundry service.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Attainment and Risk: FA

Evidence:

Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan (letter dated 12/09/2013). Fire evacuations are held six monthly and the last drill was completed 28 March 2014. There is staff across 24/7 with a current first aid certificate. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery backup. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were overall answered in a timely manner. A test of a resident call bell demonstrated an appropriate response time (less than 1 minute).

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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|--------------------------------|
| Attainment and Risk: FA |
| Evidence: |

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. A registered nurse is the restraint co-ordinator with a job description that defines the role and responsibilities. The policy identifies that restraint is used as a last resort. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies such as behaviour monitoring, sensor mats, ultra-low beds, perimeter mattresses and floor mattresses have been ineffective. The service currently has no residents on restraint. There is provision for emergency restraint and the nurse manager is contacted for prior approval for restraint to be implemented. There is a restraint committee (restraint co-ordinator, nurse manager and caregiver) meet three monthly and report to the quality committee.

Enablers are voluntary and the least restrictive option. The restraint register has documented one resident using a seatbelt as an enabler. The one file of the resident using an enabler is reviewed. The resident and family have been provided with information on use of enablers, a consent form has been signed and there is evidence of three monthly reviews. Use of the enabler is identified in the long term care plan. Risks identified with the use of enabler are not documented (link 1.3.6.1).

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The responsibility for infection prevention and control is clearly defined in the infection prevention and control guidelines. The responsibility for infection prevention control is clearly defined and there are clear lines of accountability for infection prevention control matters in the organisation leading to the leadership team, executive team and the board. The programme is reviewed annually. The policy states that the infection prevention control coordinator will be a registered nurse and there is a job description, and this is the

case at Summerset Down the Lane. The infection control coordinator is supported by the nurse manager. The facility has access to professional advice from the GP team, and from within the organisation. Staff will develop links with staff from the DHB. There is a clear process for early consultation and feedback to the infection prevention and control team. Infection surveillance forms are being implemented in line with company policy. There are guidelines and staff health policies for staff to follow ensuring prevention of the spread of infection. These include an outbreak management policy and flow chart, a pandemic plan and policy, a food handler's sickness policy and a hand hygiene policy. There are three monthly infection control meetings. The quality meetings also include a discussion and reporting of infection control matters. Information from these meetings is passed on to the staff at the weekly clinical update meetings.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control committee is made up of a cross section of staff including the nurse manager and a registered nurse (who is the infection control coordinator). The infection control coordinator provides an infection control report to the monthly quality staff meetings (minutes sighted). The infection control coordinator can access external specialist advice from doctors, laboratories, other Summerset infection control nurses and the District Health Board infection control specialists/gerontologists when required. The infection control coordinator states that there is access to all relevant resident information to undertake surveillance, audits and investigations

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA

Evidence:

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control (IC) coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed external training to undertake the IC role. The orientation package includes specific training around hand washing and hand hygiene is an annual competency. The IC coordinator provides training both at orientation and infection control training is included on the annual clinical audit, training and compliance calendar. Training has been provided in March 2014 – residents with MRSA - and June 2014 - hand hygiene. Resident education is expected to occur as part of providing daily cares.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

Infection monitoring is the responsibility of the infection control coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Summerset Down the Lane are appropriate to the acuity, risk and needs of the residents. The infection control coordinator enters infections on to the infection register and into the 'sway' database, which generates a monthly analysis of the data. The analysis is reported to the monthly quality meetings (minutes viewed). The general practitioner interviewed confirmed that staff provide information about any changes in state for a resident including if there are infections and confirms that instructions are followed up. There is evidence of general practitioner involvement and laboratory reporting in the resident files reviewed.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*